STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

September 10, 2018

Mr. Daniel McIntyre, Administrator
Charlotte Hungerford Hospital
540 Litchfield St
Torrington, CT 06790

Dear Mr. McIntyre:

Unannounced visits were made to Charlotte Hungerford Hospital concluding on August 29, 2018 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for **October 2, 2018 at 1:00 PM** in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by **September 22, 2018** or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice. The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

Connecticut Department of Public Health

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DATES OF VISIT: May 24, July 20, and August 29, 2018

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

Should you have any questions, please do not hesitate to contact this office at (860) 509-8018.

Respectfully,

Susan H. Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN/PT:jf

Complaints #23107 and #23736

DATES OF VISIT: May 24, July 20, and August 29, 2018

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing service (1) and/or (i) General (6).

1. *Based on clinical record review, facility documentation and interviews for one of three sampled patients (Patient #6) receiving oxygen in the ED, the hospital failed to ensure that a portable oxygen tank had a sufficient amount of oxygen for patient use resulting in a change in the patient's oxygen saturation level requiring intubation. The findings include:
    a. Patient #6 presented to the ED on 5/31/18 arrival time 5:38 PM, with a two day history of shortness of breath, vomiting and cough. The patient's past medical history included Chronic Obstructive Pulmonary Disease (COPD), chronic hypoxic respiratory failure, and was on continuous 6 liters of oxygen via nasal cannula at home. Patient #6 was placed on a stretcher in the emergency department hallway and received oxygen therapy via a portable oxygen tank supplied by the hospital.

    Vital signs documented at 5:43 PM included Blood Pressure 172/88 mm/Hg, Pulse 102 bpm, Respiration 32 and oxygen saturation (SaO2) level 94% on 6 liters per minute (LPM) oxygen via nasal cannula. A pulmonary assessment note by RN #3 at 5:50 PM identified diminished bilateral breath sounds, expiratory wheezing and anxious. The note also identified that the patient was removed from a non-rebreather (initiated by EMS) oxygen delivery system and placed on a nasal cannula at 6LPM, patient tolerating well at this time.

    Review of the clinical record and interviews failed to identify that the portable oxygen tank level was checked when the oxygen delivery via non-rebreather mask (which requires a minimum flow of 10 LPM) was changed to the nasal cannula.

    In an interview on 7/23/18 at 3:45 PM, RN #3 identified she was the primary nurse for Patient #6 and recalled the shift was busy. RN #3 identified the patient arrived by ambulance and the emergency medical staff (EMS) had placed the patient on a stretcher and connected the non-rebreather mask to the (hospital's) portable oxygen tank. After assessing the patient and physician notification, RN #3 changed the method of oxygen delivery from the non-rebreather to nasal cannula providing oxygen at 6 LPM at approximately 5:50 PM. RN #3 identified when she had inserted the peripheral intravenous catheter about 7:30 PM, the patient complained of shortness of breath and she went to get a monitor to assess the patient's vital signs as well as a medication. RN #3 identified shortly thereafter Person #2 had yelled that Patient #6 required help at which point other staff responded and the patient was immediately placed into an exam room for further evaluation. RN #3 identified she did not check the oxygen tank level prior to putting the nasal cannula on and was not aware of the tank contents at that time. RN #3 identified that at the time, there was no one designated as responsible for checking oxygen tank levels.

    A nursing note by RN #3 at 7:30 PM identified patient experiencing worsening shortness of breath, SaO2 level dropped to 80% and portable oxygen tank found to be empty. The note further identified the patient was moved to an exam room and placed on a non-rebreather

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mask, MD present and respiratory called to place patient on BiPAP with nebulizer treatment.

Review of the ED notes identified that although Patient #6's oxygen saturation level improved to 98% with the use of a the BiPAP, a decision was made to intubate the patient at 10:30PM due to respiratory symptoms not responding to respiratory treatments and a diagnosis of respiratory acidosis. The patient was subsequently admitted to ICU intubated for ventilator support. Review of a discharge summary dated 6/23/18 identified that Patient #6 was successfully extubated and discharged to a short term rehabilitation facility.

Interview with PA #1 on 7/20/18 at 1:40 PM identified that she examined Patient #6 and ordered oxygen via nasal cannula at 6 LPM and a respiratory treatment. PA #1 determined the patient to be stable and would be put in a room as soon as one became available. PA #1 identified that an empty oxygen tank may have been a contributing factor for the decision to intubate the patient.

In an interview on 7/20/18 at 11:50 PM, MD #4 identified Patient #2 was initially seen by PA #2, recalled that the shift was extremely busy and exam rooms were occupied therefore the patient was in the hallway until a room was made available. MD #4 recalled that Person #2 asked for Patient #6 to be checked because he/she had difficulty breathing. MD #4 identified that the patient's SaO2 level was low and that he/she was receiving oxygen via the portable tank. MD #4 identified the patient was taken to an exam room for further evaluation and treatment with respiratory therapy support. In addition, MD #4 identified he had been informed that the tank had ran out of oxygen.

Interview with the Director of Quality on 7/24/18 at 2:50 PM identified that at the time of the incident, there was no process for checking oxygen tank levels in the emergency department. The Director of Quality identified that according to the ED Nurse Manager, the person who initiated the use of the tank would be responsible for checking the contents of the portable oxygen level. As a result of the incident, the hospital initiated a process for monitoring oxygen tank levels.

Tour of the emergency department on 8/29/18 identified that all 25 patients currently receiving care and treatment were in examination rooms equiped with wall mounted oxygen delevery systems. Interview with the Manager of the emergency department on 8/29/18 at 12:20 PM identified that there are occasions when a patient would be placed on a stretcher in the hallway. However, the current practice would be for any patient requiring oxygen to be placed in an examination room, not the hallway.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2).

2. Based on clinical record review, facility documentation and interviews for one of three sampled

patients (Patient #1) reviewed for grievances, the facility failed to ensure efforts were made to provide a resolution. The findings include:

a. Patient #1 was evaluated and received treatment for respiratory symptoms at a medical walk-in center on 4/21/17 and in the emergency room on 4/23/17 on two occasions. Review of the clinical records identified Patient #1's condition deteriorated and he/she was subsequently transferred to a higher level of care with a diagnosis of bacterial pneumonia, hypoxemia and respiratory failure on 4/23/17.
Review of the patient relations report dated 5/8/17 identified Person #1 complained of incorrect treatment and quality of care for Patient #1 on 4/21/17 at the walk-in center and 4/23/17 at the emergency room. Review of the patient relations documentation identified communication between Person #1 and Patient Experience Staff #1 on 5/10/17 and 5/15/17. The patient relations report failed to reflect communication with Person #1 after 5/15/17.

In an interview and review of facility documentation on 5/24/18 at 12:50 PM, Patient Experience Staff #1 identified Person #1's complaint was assigned to her and recalled talking with Person #1 on two occasions. Patient Experience staff #1 identified that Person #1 was very busy due to Patient #1's acute illness and had informed her that he/she would be in touch later. Patient Experience Staff #1 further identified usually a complaint would be flagged for followed up but cannot recall why this was not done for this case.

In an interview and review of facility documentation on 5/24/18 at 1:40 PM, the Director of Patient Experience was unable to provide documentation that Person#1's complaint was followed through. The Director of Patient Experience identified the complaint was entered into the electronic complaint tracking software but was not identified to be followed up. The Director of Patient Experience identified staff were waiting to hear from Person #1 for continuance and that the complaint was closed without a letter issued to Person #1.The Director of Patient Experience further identified the expectation is for a grievance to be completed in 7-10 days and to provide written documentation to the complainant regarding the outcome.

Review of the facility Patient/Family Complaints and Grievance policy identified in part the facility will review, investigate and resolve patients' complaints and grievances within 7-10 business days and no later than 30 calendar days. In addition, the policy states a written response with the results of the grievance will be sent and if ongoing after 30 days the letter will indicate ongoing investigation and that another follow up response will be sent.